obtain staffing levels; and

(iii) existing dependency upon temporary nursing services in order to maintain staffing levels.

(8) A CBC is allowable for an increase in inpatient care costs generated by increased care or services required by a more intensely ill patient population. The hospital shall have the burden of demonstrating a net increase in intensity from either the base year or the last year for which a casemix adjustment has been made (whichever was later) to the intermediate or rate year. The higher intensity level in the intermediate or rate year shall be used to adjust RFR.

(a) Psychiatric Hospitals may demonstrate that increases in certain intensity factors between the base year and the intermediate year have led to increases in service intensity e.g., FTEs, nursing hours per patient), which in turn have led to quantifiable increases in cost. Intensity factors include, changes in: age mix, average length of stay, number of involuntary lockup patients, patient disability index, and percentage of patients admitted from an acute hospital. Note that increases in inputs alone are not enough to qualify for an intensity CBC; some intensity-related change in patient characteristics must also be identified.

(b) If the documentation for the increase in intensity is found to be acceptable then the hospital shall have the burden of documenting the increase in patient care costs resulting from the higher level of

intensity.

(9) Costs for increases in physician malpractice insurance premiums paid by the hospital for physicians who are employees of the hospital and who do not bill patients or third-party reimbursers separately for their professional services. The amount of the approved exception allowance will be the net of all the increases already determined through the inflation allowance for malpractice insurance premiums from the base year forward and included in the hospital's Medicaid rates. The hospital must document the actual malpractice insurance premium expense, as well as show that the physicians covered are employees of the hospital and do not bill separately for their services. The hospital may include in the CBC request the amount of any retroactive premium payments to be made during the rate year.

No costs other than those meeting the criteria set forth in one or more of the above categories shall constitute a cost beyond the reasonable control of the hospital.

4. New Services

Certain health services that were not offered by a hospital in the base year, meeting the data reporting and other requirements described in Section III.A herein, are included in the operating requirements as new services. The allowable cost for a new service is equal to the reasonable operating costs attributed to the new service cost centers.

5. Capital.

The base year capital requirement shall be adjusted to include reasonable projected acquisitions and retirements of fixed equipment and plant, and reasonable projected increases

and decreases in amortization, leases and rentals, subject to the limitations contained in Section III.A.1 herein.

III.C. Determination of Reasonable Financial Requirements (RFR) for the Rate Year

The rate-year RFR is calculated with the following formula:

RFR =

(Rate-Year Operating Requirement +Rate-Year Capital Requirement + Rate-Year Working Capital Requirement)

1. The rate year operating requirement is the sum of the base-year allowed operating cost and the adjustment of the base-year allowed operating costs to the rate year.

2. The rate year capital requirement is the sum of the base-year allowed capital and the adjustment of the base year capital to the rate year.

3. The rate-year working-capital requirement will be determined by multiplying the sum of the rate-year operating and capital requirements by 0.0055.

III.D. Determination of Approved Gross Patient Service Revenue for the Rate Year

A State-owned non-acute hospital's GPSR is its total dollar amount of its projected Charges for the rate year.

III.E. New Hospital

For new hospitals, which were not licensed and/or operated as State-owned non-acute hospitals in RY 1998, or did not have a base year previously established , the Division may consider alternative data sources to determine Base Year costs. Criteria for such review will include but will not be limited to peer group analysis of costs incurred and the determination of approved rates for comparable

facilities.

III.F. Rates of Payment for Medicaid Services

1. For all State-Owned Non-Acute Hospital services, the Medicaid rate of payment is equal to the payment-on-account factor (PAF) multiplied by the approved charge for each eligible service provided to a Recipient under the Medicaid program.

2. A State-Owned Non-Acute Hospital's PAF is computed by dividing its approved RFR by its GPSR.

IV. Medicaid Disproportionate Share Adjustments

The Medicaid program will assist hospitals which carry a disproportionate financial burden of caring for the uninsured and low income persons of the Commonwealth. In accordance with Title XIX rules and requirements, Medicaid will make an additional payment adjustment to hospitals which qualify for such an adjustment. Eligibility requirements for each type of disproportionate share adjustment and the methodology for calculating these adjustments are described below.

(1) To qualify for any type of disproportionate share payment adjustment, a hospital must have a Medicaid inpatient utilization rate (calculated by dividing MassHealth patient days by total patient days) of not less than 1%.

(2) The total of all disproportionate share payments awarded to a particular hospital in a particular year shall not exceed the costs incurred during the year of furnishing hospital services to individuals who either are eligible for Medicaid or have no health insurance or source of third party coverage, less payments by Medicaid and by uninsured patients.

(3) Disproportionate share payments made pursuant to this section are subject to Health Care Financing Administration approval of state

plan amendments incorporating this methodology.

V. Federally Mandated Disproportionate Share Adjustments

(1) Data Sources. The Division shall determine for each fiscal year a federally-mandated Medicaid disproportionate share adjustment for all eligible hospitals, using the data and methodology described below. The prior year DHCFP-403 report shall be used to determine Medicaid days, total days, Medicaid inpatient net revenues, total inpatient net revenues, total inpatient charges and free care charge-off. If said DHCFP-403 report is not available, the Division shall use the most recent available prior year DHCFP-403 report to estimate these variables.

(2) Determination of Eligibility Under the Medicaid Utilization Method. The Division shall calculate a threshold Medicaid inpatient utilization rate to be used as a standard for determining the eligibility of all non-acute care hospitals for the federally-mandated disproportionate share adjustment. The Division shall determine such threshold as follows:

(a) First, calculate the statewide weighted average Medicaid inpatient utilization rate by dividing the sum of Medicaid days for all non-acute care hospitals in the state by the sum of total inpatient days for all non-acute care hospitals in the state.

(b) Second, calculate the statewide weighted standard deviation for Medicaid inpatient utilization statistics.

(c) Third, add the statewide weighted standard deviation for Medicaid inpatient utilization to the statewide weighted average Medicaid inpatient utilization rate. The sum of these two numbers shall be the threshold Medicaid inpatient utilization rate.

(d) The Division shall then calculate each hospital's Medicaid inpatient utilization rate by dividing each hospital's Medicaid

Medicaid utilization rate calculated pursuant to Section V. (2)(c). The ratio resulting from such division shall be the federally-mandated disproportionate share ratio.

(b) For each hospital determined eligible for the federally mandated disproportionate share adjustment under the low-income utilization rate method, but not found to be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method, the Division shall set the hospital's federally-mandated disproportionate share ratio equal to one.

(c) The Division shall then determine, for the group of all eligible hospitals, the sum of federally mandated disproportionate share ratios calculated pursuant to Section V. (4)(a) and Section V. (4)(b).

(d) The Division shall then calculate a minimum payment under the federally-mandated disproportionate share adjustment by dividing the amount of funds allocated for payments under the federally-mandated disproportionate share adjustment by the sum of the federally-mandated disproportionate share ratios calculated pursuant to Section V. (4)(c).

(e) The Division shall then multiply the minimum payment under the federally-mandated Medicaid disproportionate share adjustment by the federally-mandated Medicaid disproportionate share ratio established for each hospital pursuant to Section V. (4)(a) and (b). Subject to the limits herein, the product of such multiplication shall be the payment under the federally-mandated disproportionate share adjustment.

Medicaid utilization rate calculated pursuant to Section V.(2)(c). The ratio resulting from such division shall be the federally-mandated disproportionate share ratio.

(b) For each hospital determined eligible for the federally-mandated disproportionate share adjustment under the low-income utilization rate method, but not found to be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method, the Division shall set the hospital's federally-mandated disproportionate share ratio equal to one.

(c) The Division shall then determine, for the group of all eligible hospitals, the sum of federally-mandated disproportionate share ratios calculated pursuant to Section V.(4)(a) and Section V.(4)(b).

(d) The Division shall then calculate a minimum payment under the federally-mandated disproportionate share adjustment by dividing the amount of funds allocated pursuant to Section V.(5) for payments under the federally-mandated disproportionate share adjustment by the sum of the federally-mandated disproportionate share ratios calculated pursuant to Section V.(4)(c).

(e) The Division shall then multiply the minimum payment under the federally-mandated Medicaid disproportionate share adjustment by the federally-mandated Medicaid disproportionate share ratio established for each hospital pursuant to Section V.(4)(a) and (b). Subject to the limits herein, the product of such multiplication shall be the payment under the federally-mandated disproportionate share adjustment.

VI. Extraordinary Disproportionate Share Adjustment for Special Population State-Owned Non-Acute Hospitals.

The Division shall determine an extraordinary disproportionate share adjustment for all eligible State-Owned Special Population Non-Acute Hospitals, using the data and methodology described below.

(1) Data Sources.

The Division shall use the DHCFP-403 report for the fiscal year two years prior to the fiscal year of the calculation of the disproportionate share adjustment to determine the cost, free care, charge, patient day, and net revenue amounts. If said DHCFP-403 report is not available, the Division shall use the most recent available previous DHCFP-403 report to estimate these variables. If the specified data source is unavailable, then the Division shall determine and use the best alternative data source.

(2) Determination of Eligibility.

(a) In order to be eligible for the extraordinary disproportionate share payment adjustment, a State-Owned Non-Acute Hospital must:

1. specialize in providing treatment to people with AIDS, tuberculosis patients, the medically needy homeless, multiply handicapped pediatric patients and patients with combined medical and psychiatric needs;
2. provide for special active treatment such as treatment of deafness, developmental disabilities, and the elderly;
3. accept all patients without regard to their ability to pay;
4. meet requirements for the receipt of federal matching funds;
5. meet the low-income standard as set forth in Section VI.(2)(b); and
6. meet the unreimbursed cost standard as set forth in Section VI.(2)(c).

(b) Low-income standard.

1. For each state-owned special population non-acute hospital, the Division shall calculate the hospital-specific low-income utilization rate as follows:

   a. The Division shall divide each hospital's net Medicaid revenue by its total gross patient service revenue.
   b. The Division shall divide each hospital's free care charges by its total charges.
   c. The total of these percentages shall equal the hospital's low-income utilization rate.

2. If the hospital-specific low-income utilization rate exceeds 45%, then the state-owned special population non-acute hospital meets the low-income standard.

(c) Unreimbursed cost standard.

1. For each state-owned special population non-acute hospital, the Division shall calculate the hospital-specific unreimbursed cost percentage as follows:

   a. The Division shall calculate the costs of providing hospital services to Medicaid-eligible individuals and uninsured individuals, by multiplying Medicaid RFR by the ratio of Medicaid charges plus self pay charges plus free care charges to total charges.
   b. The Division shall subtract the total of Medicaid payments (excluding any disproportionate share payments) plus self pay payments, from the costs determined in Section VI.(2)(c)1.a., to determine the amount of unreimbursed costs.
   c. The Division shall divide the amount of unreimbursed costs determined in Section VI.(2)(c)1.b. by the costs determined in Section VI.(2)(c)1.a. to determine the percentage of unreimbursed costs.

2. If the hospital-specific percentage of unreimbursed costs exceeds 50%, then the state-owned special population non-acute hospital meets the unreimbursed cost standard.

(3) Determination of Payment. Subject to the limits herein, for each state-owned special population non-acute hospital determined eligible for the extraordinary disproportionate share adjustment under Section VI(.2), the payment amount shall be equal to the estimated rate year unreimbursed cost of providing hospital services to Medicaid-eligible individuals and uninsured individuals, calculated as follows:

(a) First, determine the estimated rate year cost of providing hospital services to Medicaid-eligible individuals and uninsured individuals as set forth in Section VI.(2)(c)1.a., substituting RY Reasonable Financial Requirements for source data RFR.

(b) Then, multiply this cost by the unreimbursed cost percentage determined pursuant to Section VI.(2)(c)1.c.

VII. Extraordinary Disproportionate Share Adjustment for State Owned Psychiatric Hospitals

The Division shall determine an extraordinary disproportionate share adjustment for all eligible State-Owned Psychiatric Hospitals, using the data and methodology described in Section VII.

(1) Data Sources.

The Division shall use the DHCFP-403 report for the fiscal year two years prior to the fiscal year of the calculation of the disproportionate share adjustment to determine the cost, free care, charge, patient day, and net revenue amounts. If said DHCFP-403 report is not available, the Division shall use the most recent available previous DHCFP-403 report to estimate these variables. If the specified data source is unavailable, then the Division shall determine and use the best alternative data source.

(2) Determination of Eligibility.

(a) In order to be eligible for the extraordinary disproportionate share payment adjustment, a State-Owned Psychiatric Hospital must:

1. specialize in providing psychiatric/psychological care and treatment;
2. provide for special active treatment such as treatment of deafness, developmental disabilities, and the elderly;
3. accept all patients without regard to their ability to pay;
4. consist partly or wholly of locked wards;
5. meet requirements for the receipt of federal matching funds;
6. meet the low-income standard as set forth in Section VII.(2)(b); and
7. meet the unreimbursed cost standard as set forth in Section VII.(2)(c).

(b) Low-income standard.

1. For each state-owned psychiatric Hospital, the Division shall calculate the hospital-specific low-income utilization rate as follows:

   a. The Division shall divide each hospital's net Medicaid revenue by its total gross patient service revenue.
   b. The Division shall divide each hospital's free care charges by its total charges.
   c. The total of these percentages shall equal the hospital's low-income utilization rate.

2. If the hospital-specific low-income utilization rate exceeds 45%, then the state-owned psychiatric hospital meets the low-income standard.

(c) Unreimbursed cost standard.

1. For each state-owned psychiatric hospital, the Division shall calculate the hospital-specific unreimbursed cost percentage as follows:

   a. The Division shall calculate the costs of providing hospital services to Medicaid-eligible individuals and uninsured individuals, by multiplying Medicaid RFR by the ratio of Medicaid charges plus self pay charges plus free care charges to total charges.
   b. The Division shall subtract the total of Medicaid payments (excluding any disproportionate share payments) plus self pay payments, from the costs determined in Section III(2)(c)1.a., to determine the amount of unreimbursed costs.
   c. The Division shall divide the amount of unreimbursed costs determined in Section III(2)(c)1.b. by the costs determined in Section III(2)(c)1.a. to determine the percentage of unreimbursed costs.

2. If the hospital-specific percentage of unreimbursed costs exceeds 50%, then the state-owned psychiatric hospital meets the unreimbursed cost standard.

(3) Determination of Payment. Subject to the limits herein, for each state-owned psychiatric hospital determined eligible for the extraordinary disproportionate share adjustment under Section III(2), the payment amount shall be equal to the estimated rate year unreimbursed cost of providing hospital services to Medicaid-eligible individuals and uninsured individuals, calculated as follows:

   a. First, determine the estimated rate year cost of providing hospital services to Medicaid-eligible individuals and uninsured individuals as set forth in Section VII.(2)(c)1.a., substituting RY Reasonable Financial Requirements for source data RFR.
   b. Then, multiply this cost by the unreimbursed cost percentage determined pursuant to Section VII.(2)(c)1.c.

(4) Limits on Allocation of Funds. The total amount of funds allocated for payment to state owned psychiatric hospitals shall be proportionately reduced to stay within the limits for disproportionate share payments for institutions for mental diseases (IMDs) reported by the Commonwealth to Health Care Financing Administration in accordance with limits pursuant to 42 U.S.C. 1396r-4.

VIII. Disproportionate Share Outlier Adjustment For Infants Under One Year of Age.

The Division will make an annual payment adjustment to state owned non-acute hospitals for services furnished to infants under one year of age involving exceptionally high costs or exceptionally long lengths of stay. Determination of eligibility for this outlier payment adjustment for infants under one year of age is described in Section VIII.(1) and (2) below.

(1) Exceptionally Long Lengths of Stay.

(a) First, calculate a statewide weighted average Medicaid inpatient length of stay. This shall be determined by dividing the sum of Medicaid days for all non-acute care hospitals in the state by the sum of total discharges for all non-acute care hospitals in the state.

(b) Second, calculate the statewide weighted standard deviation for Medicaid inpatient length of stay statistics.

(c) Third, take 1.5 times the statewide weighted standard deviation for Medicaid inpatient length of stay; add that result to the statewide weighted average Medicaid inpatient length of stay. That sum shall constitute the Medicaid threshold for an exceptionally long length of stay for purposes of payment adjustments under this Section.

(2) Exceptionally High Cost.

(a) First, calculate the average cost per Medicaid inpatient discharge for each hospital.

(b) Second, calculate the standard deviation for the cost per Medicaid inpatient discharge for each hospital.

(c) Third, take 1.5 times the hospital's standard deviation for the cost per Medicaid inpatient discharge; add that result to the hospital's average cost per Medicaid inpatient discharge. That sum shall constitute the Medicaid threshold for an exceptionally high cost for purposed of payment adjustments under this Section.

(3) Allocation of Funds. The total amount of funds allocated shall be twenty five thousand dollars ($25,000). Any hospital which qualifies for an outlier adjustment shall receive a payment of one percent of the total allocation of funds. In the event that qualifying hospitals exceed the total, each hospital's share shall be proportionately reduced to stay within the allocation.

IX. Disproportionate Share Outlier Adjustment For Children Under Six.

Disproportionate share outlier adjustment in payment amount for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay, as defined in Section VIII, is extended to services for children who have not reached the age of six, provided that the state owned non-acute hospital qualifies as a disproportionate share hospital under Section V.